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TWO CASES OF ABDOMINAL SECTION: (1) PYOSAL-
PINX; INTRAPERITONEAL ABSCESS; ENCYSTED
PERITONITIS SIMULATING SO CALLED
URACHAL CYST; (2) HYDROSALPINX;
HÆMATOMA OF OVARY; TUBO-
OVARIAN CYST.

CLINICAL LECTURE DELIVERED BEFORE THE POST GRADUATE MEDICAL
SCHOOL AT THE WOMAN'S HOSPITAL OF CHICAGO.

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Gentlemen:—The case now being anesthetized is one of great interest. Whether we will find a pyosalpinx or tuberculosis of the appendages, I cannot positively determine until the abdomen is opened. She came to the hospital two weeks ago, with a daily afternoon temperature of one hundred to one hundred and one degrees F. She was about on her feet, but had considerable pelvic pain, was extremely emaciated and haggard looking, and had the physical signs of incipient pulmonary phthisis. She is thirty-six years old, married twelve years, has three children, youngest six years. She has never been bedridden except from an attack of pneumonia one year ago, and at her confinements. After the last one she was in bed two weeks, and got about rather slowly. In case this should be pyosalpinx, the only cause obtainable in the history, is the birth of the last child, since which time she has had pains in the lower abdomen before menstruating, and occasional attacks of menorrhagia.

A vaginal examination revealed a fixation of the uterus in about normal position with indurated tissue behind and at both sides. Rectal indigitation revealed hard tissue laterally, and a semi-fluctuating mass over the cul-de-sac of Douglas. In view of the fact that there was no history of acute attacks of pelvic trouble, yet a constant temperature, and a vague feeling of fullness and fluctuation in the lower abdomen, together with the general cachectic appearance and local pulmonary signs, the possibility of pelvic tuberculosis was entertained. Yet the variety of this form of disease and

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the frequency of pyosalpinx always incline me to suspect the latter.

One thing may be said, however, viz., the condition is serious and calls for abdominal section.

It is remarkable how patients like this will keep on their feet and carry their ailments about the house and country, while others with much less local trouble will keep the bed. The patient in the ward bed next to the one our patient occupied, has been bedridden for over a year with retroversion and prolapse of a slightly enlarged ovary, which is not even tender. Our patient we have put to bed and dieted for two weeks to get her in condition for an operation, and the improvement in her looks and local condition under this rest treatment, has been surprising. The temperature remains below 100 degrees F., and she has taken on flesh. The other one is also being prepared for operation, but by a diametrically opposite course of treatment, viz., by being got out of bed every day, and diligently fed. The limbs were like broomsticks, and the circulation so feeble that I dared not put her under ether long enough to perform an Alexander operation and perineorrhaphy, until her strength should be improved. She is also gaining rapidly by being made to get up and take more exercise and more food.

As everything is ready, we will rapidly open the abdomen. I find the omentum adherent to the abdominal wall from above the umbilicus to the pubes. It is as thick as the hand, and looks like a piece of placenta. The peritoneum at the place of adhesion looks as if destroyed, and is pinkish gray and granular to the sight and touch, and hanging to the edges of the separated omentum are thickened friable shreds of it that look like a cyst wall. The serum contains some whitish flakes, would measure about a quart, and is apparently shut off from the general peritoneal cavity by frail adhesions. The pelvis is filled as with a solid mass. The peritoneum reflects directly from the fundus uteri to the pubes without any indication of any vesical pouch or bladder, although the latter must of course be underneath, between the uterus and pubic bones. Just in front of the uterus the normal peritoneum is replaced by the granular surface just mentioned, from which the thickened omentum has been separated. On either side, the upper edges of the broad ligaments extend to the sides of the pelvis like thick guyropes, projecting a little from the general mass while posteriorly, the pelvis is full up to the fundus uteri and promontory of the sacrum. Thus the appearance is as if the peritoneum never had entered the pelvis, and we seem to have quite a typical case of

what Lawson Tait and Robinson call urachal cyst with tuberculous appendages.

Now, how shall we get this pelvis cleared out? I cannot get down at the sides of the pelvis, so I work the finger ends of my left hand down between the central mass and the sacrum, and suddenly break into a small cavity of fluid, which in similar cases I have found to contain serum and flaky matter. As it comes up it proves to be pus, so we must exercise great care not to spread this about. It has already touched the omentum, uterus and a loop of the intestines. I carefully keep my left hand just where it was, with the palm transversely, so as to hold the incision open and the intestines out of the way, and carefully sponge out. We will request all nurses to stand to one side, and not touch these septic sponges. Dr. White, our second assistant, will squeeze them out and wash them. Having sponged out the pus, I wipe a little soft, cheesy looking matter from the bottom of the cul-de-sac of Douglas. Now Dr. White and I will disinfect our hands and the sponges in a one or two thousandth bichloride solution, and sponge out carefully again. Now I will dismiss Dr. White, and these sponges as they are septic, call for fresh basins, disinfect my own hands again, recall the nurses, and take fresh sponges and pack them over the intestines above the infected area.

I am now able to loosen up the tubes from the bottom of the lateral sacro-peritoneal pouches, but as the broad ligaments are fleshy and friable, find it very difficult to get a pedicle. The left broad ligament tears out, and the ligature cuts so that only the isolated Fallopian tube remains in it. Yet, strange to say, there is but little bleeding. I touch a little strong carbolic acid to the somewhat dilated section of the tube left on the stump, to forestall infection. The ligature on the other stump cuts entirely through, so that none is left on it; yet, still stranger to say, there is but moderate bleeding. Oftentimes, in cases like this, the spermatic or ovarian artery will bleed, and require ligaturing. Without removing the large sponges that shut off the general peritoneal cavity, we will irrigate the pelvic cavity with several gallons of water as hot as I can bear on my hand as I hold the sponges in place. It is often said that hot water checks hemorrhage, but I usually find that even when as hot as I dare use it in the peritoneal cavity it either increases it, or has but little effect. In this case it tends to increase it. Now, we have washed out and sponged out, we will pack these small sponges firmly in the pelvis, and leave them until the external stitches are put in and ready to tie, then take them out, put a glass drainage tube into the cul-de-sac to draw off the subsequent oozing, and close up around it.

Most German operators would in this case enlarge the incision, evert the intestines and sew up bleeding surfaces, so as to be able to close without drainage. I do not like to expose either the intestines or the unhealthy tissue to such manipulation, nor do I like to leave so many ligatures, for fear they may become infected,

and prove more dangerous than the drainage tube. The discharge of infected ligatures, keeping the patient in a state of discomfort and anxiety for months and sometimes years, is quite a common after result of abdominal section. Their infection may be primary at the time of the operation, or secondary from leaving the drainage tube in too long. The tube should usually be removed in twenty-four or thirty-six hours. Infection is apt to result from leaving it longer.

Our next case is that of a virgin, Miss Florence M., aged thirty five years, who had an attack of peritonitis twelve years ago, and has ever since complained of pelvic symptoms. Her health is destroyed to such a degree, that she is a poor subject for an operation. She has scarcely any temperature, and but little tenderness in the pelvis, yet she complains of pelvic distress, and has hard indurated masses on each side of the uterus. Until I saw her, no one ever suggested a laparotomy.

We rapidly cut through the abdominal walls and find large masses adherent to the posterior surfaces of the broad ligaments. But it is almost impossible to loosen anything. The tubes are cystic, and tear the broad ligaments as they are separated. The right mass, which I have pulled up, is extremely interesting. It is, as you see a hydrosalpinx the size of the thumb, with a tubo-ovarian cyst at the fimbriated extremity, the size of a walnut.

We may have three kinds of tubo-ovarian cysts. In one case the fimbriated extremity of the tube adheres to the ovary, and the retained serum, blood or pus is retained in a sac made up of the wall of the tube and the substance of the ovary. In another case an ovarian cyst, cystoma, or abscess, grows into the fimbriated extremity of the tube until its walls finally adhere to and coalesce with the inner surface of the tube. In the third kind, which may be a more advanced stage of the second, the ovarian cyst, cystoma or abscess, may burst into the lumen of the adherent tube, so that both tube and ovary form a part of the resulting cyst.

In this case we have both the first and second varieties, viz: A hydrosalpinx whose walls are both tubal and ovarian, and an ovarian cyst developed into the lumen of the adherent tube. If this ovarian cyst had remained until it burst into the tube, we would have had the third variety. The specimen is quite a rare one.

The other tube is a simple hydrosalpinx. Under it I find a deeply bedded cyst, the size of a hen's egg, which bursts in my fingers as I enucleate it, and allows a black bloody fluid to escape. It comes up and proves to be an ovarian cyst into which hemorrhage has taken place. Although both sides are ligatured, the hemorrhage in this case is greater than in the previous one, for the adhesions are older and firmer, and have torn the peritoneum from the broad and sacro-uterine ligaments. If an operation has to be done for such conditions, it should, therefore, be done as early in the course of the ailment as possible, that the adhesions may not be so firm and the pelvic disorganization so great. We wash out and pack the pelvis as before, sew up and put in a drainage tube.